

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE HMO APPEAL AND
GRIEVANCE PROCESSES**

Beneficiaries' Understanding



**JUNE GIBBS BROWN
Inspector General**

**DECEMBER 1996
OEI-07-96-00281**

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EXECUTIVE SUMMARY

PURPOSE

To determine whether Medicare beneficiaries enrolled in risk-based Health Maintenance Organizations (HMOs) understand their appeal and grievance rights.

BACKGROUND

Beneficiaries may join a risk HMO through the Medicare program. For a predetermined monthly amount, the HMO provides Medicare covered medically necessary services. The goals of this coverage are to provide coordinated medical care, offer comprehensive benefits, and contain costs by using the most cost-efficient methods of treatment and preventing unnecessary care. As a protection for beneficiaries, the Social Security Act requires Medicare HMOs to have two separate and distinct processes, an appeal and a grievance process, to handle beneficiary complaints.

In order to protect beneficiaries from inappropriate denials of services or payment, the Act requires that Medicare HMOs establish an appeal process to handle these types of complaints. If an enrollee disagrees with the HMO decision to deny services or payment, the enrollee has 60 days to file a request for reconsideration. If the HMO's decision is against the beneficiary in whole or in part, the HMO is required to automatically send the case to the Network Design Group within 60 days for an independent Federal review.

All other complaints such as those relating to quality of care are processed under a separate internal grievance procedure. Under this procedure, there are no specific time frames or preordained levels of review established by law. However, HMOs are responsible for timely transmission, an investigation, decision, and notification of the results.

We collected information about beneficiaries' experiences with appeal and grievance rights through a mail survey of 222 randomly selected enrollees and 204 disenrollees. We supplemented the mail survey with telephone interviews of 17 beneficiaries who indicated that they had filed a complaint.

FINDINGS

Eighty-six percent of respondents were knowledgeable about their general right to make a formal complaint about their HMO's medical care or services.

Most respondents stated that they know they have the right to complain about their plan's medical care or services. Sixty-six percent of respondents stated that they were informed of their appeal and grievance rights when they first joined the HMO.

However, beneficiaries were less aware of specific instances on which they might exercise their appeal and grievance rights.

The level of beneficiaries' understanding of specific appeal and grievance situations was lower than their general knowledge. For example, 59 percent of enrollees were aware they could complain about the HMO refusing to pay for emergency care and only 49 percent of enrollees knew they could appeal an early discharge from the hospital. Also, disenrollees were significantly less informed than enrollees (e.g., enrollees were twice as likely as disenrollees to be knowledgeable of their right to appeal a non-hospital admission or early hospital discharge, and three times as knowledgeable of their ability to contest the plan's refusal to pay a doctor or hospital for emergency care for which they were billed).

Additionally, 45 percent of the respondents did not know, or were not sure that certain complaints are classified as appeals while others are classified as grievances. The distinction between appeals and grievances is important to beneficiaries because appeal cases (denials of services or payment) are subject to independent Federal review for appropriateness of the HMO decision while grievances (such as quality of care issues) are only subject to HMO internal reviews.

Most of the beneficiaries who considered they were denied services or payment were not given initial determination notices.

Thirty-four of the 41 respondents who believed their primary doctor refused to refer them to a specialist indicated they did not receive a denial letter (called an "initial determination notice"), as required by Federal regulations. Also, only 21 out of 39 respondents who reported their plan refused to pay a claim for services indicated receiving a letter furnishing their appeal rights.

Very few respondents reported filing a formal complaint. All of these complaints were resolved at the initial dispute level.

Only 26 respondents reported having filed complaints. Thirteen reported receiving a favorable resolution, seven received unfavorable decisions, five were not sure if their decision was favorable, and one beneficiary did not respond. All complaints were resolved at the initial HMO dispute level, or simply dropped by the beneficiary. No one requested further review of their denied complaints.

RECOMMENDATIONS

Health Care Financing Administration's (HCFA) Office of Managed Care is making substantial efforts to improve the HMO appeal and grievance processes. It has recently created a work group - Managed Care Appeals and Grievance Initiative - organized to make program improvements in these functions. Appeals language has been standardized in "lock in" and Evidence of Coverage notices, which are sent to all beneficiaries when they enroll in an HMO. In addition, appeal and grievance

information was included in the 1996 Medicare Handbook, and expanded information on appeals was incorporated into HCFA's Managed Care Directory. Currently HCFA is working with HMOs to develop national guidelines for marketing materials.

HCFA also announced plans to produce a Managed Care Appeals Publication, an HMO Comparability Chart, a national data base of managed care "Questions and Answers", and a Managed Care Fraud and Abuse Publication. They are continuing to educate outside entities, including advocacy groups, by providing more information on managed care matters, as well as highlighting beneficiary rights and protections in a managed care setting. While HCFA's efforts should continue to have favorable impact, we believe there is still room for improvement.

To receive full benefits of the appeal and grievance protections, beneficiaries need to be aware of the processes, understand how the processes work, and when to use them. In that vein, HCFA should

- ***actively monitor HMOs to ensure beneficiaries are issued written determinations, including appeal rights, and emphasize the need for beneficiaries to communicate clearly any disagreement they have with HMO decisions to deny services or payment for services.*** This can be accomplished by:

- continuing HCFA's extensive efforts to make beneficiaries aware of appeal and grievance provisions and of the need to communicate clearly any disagreement they may have with a physician's decision to deny a requested service and
- emphasizing to HMOs the requirements to make beneficiaries aware of appeal and grievance rights and to provide written initial determination notices when the patient communicates disagreement with a decision to deny a requested service or payment.

Federal regulations are intended to protect the rights of beneficiaries to appeal the denial of services by HMOs, while maintaining the ability of the physician to treat the patient in line with his or her medical judgement. It is not always possible at the time of service for the physician to know whether a beneficiary believes that a service has been denied unless the beneficiary specifically communicates this to the physician. Therefore, future HMO marketing, enrollment, and awareness sessions with Medicare beneficiaries and physicians should emphasize the importance of clear and open communication.

- ***work with HMOs to establish standardized appeal and grievance language requirements in marketing/enrollment materials and operating procedures.***

- In marketing materials, provide up front information to beneficiaries on their rights under the appeal and grievance processes and

- In enrollment materials, more thoroughly educate beneficiaries about their specific rights under the appeal and grievance processes, including
 - a detailed overview of the types of services, lack of services, or situations which may be appealed or grieved.
 - when and under what circumstances further levels of appeal are permitted.
 - clarification that only appeals and not grievances, are subject to independent Federal review.
 - the difference between the definitions of emergency and urgent care at the time medical services are being sought.

AGENCY COMMENTS

We solicited and received comments on our draft report from HCFA. They agreed with the conclusion of our reports that improvements are needed and indicated that they are working to implement a number of our recommendations. We are pleased that HCFA agrees that improvements are needed in the appeal and grievance processes, and we recognize that changes are in the process of being made through the Medicare Appeals and Grievance Initiative (MAGI). However, because HCFA's response does not specifically address the recommendations contained in our reports, we are unsure whether the problems identified in our report will be fully addressed through this initiative. As a result, it will be important for HCFA to include in their response to the final report an action plan that specifically addresses each recommendation.

The full text of HCFA's comments is included as an appendix to this report.

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RELATED REPORTS

This is one of a series of four reports relating to Medicare risk HMO appeal and grievance processes. The four reports are:

Medicare HMO Appeal and Grievance Processes: Overview, (OEI-07-94-00280),

Medicare HMO Appeal and Grievance Processes: Beneficiaries' Understanding, (OEI-07-94-00281),

Medicare HMO Appeal and Grievance Processes: Survey of HMOs, (OEI-07-94-00282),

Medicare HMO Appeal and Grievance Processes: Review of Cases, (OEI-07-94-00283),

INTRODUCTION

PURPOSE

To determine whether Medicare beneficiaries enrolled in risk-based Health Maintenance Organizations (HMOs) understand their appeal and grievance rights.

BACKGROUND

Legislation

Sections 1833 and 1876 of the Social Security Act specify the requirements that HMOs must meet in order to enter into a contract with the Health Care Financing Administration (HCFA) to furnish Medicare covered services to beneficiaries. The goals of HMO coverage are to provide access to medical care while containing costs by using the most cost-efficient methods of treatment and preventing unnecessary care. In addition, HMOs can reduce the medical management complexities experienced by elderly patients with multiple chronic conditions, the paperwork burden of a "fee for service" system, and financial barriers to obtaining preventive and medically necessary health care.

Unlike traditional "fee for service," HMOs are designed to coordinate care through a primary care provider, offer comprehensive benefits, and reduce or contain the costs of medical treatment. They operate under a fixed annual budget, based on the prepaid premiums by patients. Except for fees of a few dollars for each doctor's visit or prescription, the premium is to cover all of a patient's medical needs which include everything from checkups to open-heart surgery.

Risk and Cost Plans

There are three types of Medicare HMO plans included in the Act. Generally, the differences involve the method used by HCFA to reimburse the HMO for providing services and delivering medical services to beneficiaries. The three types of contracts are risk-based, cost-based, and Health Care Prepayment Plan (or HCPP) HMOs. The latter two types are paid on a reasonable cost basis, wherein any differences in actual costs and interim payments are reconciled and adjusted with HCFA at the end of the year. Risk-based are reimbursed on a prepaid capitation basis with no retrospective adjustment. While cost-based and HCPP HMOs give beneficiaries a choice of physicians that they see, a risk-based plan requires enrollees to be "locked" into only its contracted physicians unless emergency or urgent care is needed.

As of March 1, 1996, there were 197 risk-based HMO plans, 27 cost-based plans, and 54 HCPPs nationwide, which accounted for almost 4 million Medicare HMO enrollees, or 10 percent of the total Medicare population. While Medicare enrollment in managed care has increased 67 percent since 1993, HCFA reports that enrollment in risk-based plans has grown 105 percent.

Appeals & Grievance Processes

One of the most effective ways HMOs contain costs is by using family practitioners or internists as "gatekeepers" to control a patient's access to services. The patient chooses one doctor as a primary care physician; from then on that doctor serves as first arbiter for any treatment. The primary care physician provides medical examinations and treatments, and serves as a "gatekeeper" to specialty care, except in emergency and urgent care situations.

Because the payment mechanism of HMOs provides a strong incentive to manage utilization of enrollee medical services (including the institution of a physician "gatekeeper" and use of medical practice guidelines), the Act requires that HMOs establish an appeal process to handle disputes Medicare enrollees have involving a denial of or payment for services they believe should be covered by the HMO. Other kinds of complaints such as quality of care received are handled under a grievance procedure. Prior to May 1995, only risk and cost-based plans were required to have these processes. HCPPs now must also comply with these requirements.

HCFA directives require HMOs to inform beneficiaries of their appeal/grievance rights at enrollment, in member handbooks, and annually through a newsletter or other communication.

Appeals process - According to 42 CFR, Sections 417.600-638, an appeal is any dispute involving a denial of services or payment for services made by the HMO. Federal regulations and the HMO/CMP¹ Manual require a five-step process and time limits for each step. HMOs must make an initial determination upon receiving an enrollee's request for services or payment for services within established time frames (24 days if the case is complete and no later than 60 days if development is needed). Each plan is required to make a decision on information they currently have within this time frame. If the decision is to deny services or payment, the enrollee has 60 days from the date of the initial determination to file a request for reconsideration in writing unless "good cause" can be shown by the beneficiary for the delay. The HMO then has 60 days to make a reconsideration decision.

If the HMO's reconsideration decision is against the beneficiary in whole or in part, the HMO is required to automatically forward the case to HCFA for an independent review to determine if the decision is appropriate. Due to the increasing numbers of appeal cases, HCFA contracted with Network Design Group (NDG) in January of 1989 to fulfill this function. The number of appeals reviewed by NDG has varied in the last 3 years from a high in 1993 of 3,806, to 2,945 in 1994, and 3,691 in 1995.

Beneficiaries whose cases are not resolved fully in their favor at the NDG level can request a hearing before an Administrative Law Judge (ALJ) if the disputed amount is at least \$100. After this level, any party (including the HMO) may request a review by the Department of Appeals Board if there is dissatisfaction with the ALJ's decision or dismissal. The final recourse in the appeals process is a Federal court review if the

¹ Competitive Medical Plan

Board denies the party's request for review, and the amount in controversy is \$1,000 or more.

Grievance process - Grievances are any complaints about a Medicare enrollee's experience with the health plan and/or its providers, excluding determinations involving payment for services or denial of services (which are subject to the appeals process). Examples of grievable issues include quality of care, physician behavior, involuntary disenrollment concerns, and waiting times for services.

Guidance for processing grievances is found in 42 CFR, Sections 417.600 and 417.606, and in Section 2411 of the HMO/CMP Manual. The guidelines do not provide for time frames or specify levels of review, but call for "timely" transmission, an investigation, decision, and notification of the results. While appeal cases that are not resolved in favor of the beneficiaries are subject to independent HCFA, ALJ, Appeals Board, and Federal court review, beneficiary grievances are only subject to internal levels of review within the HMO.

The Office of Managed Care (OMC) within HCFA is responsible for policy and oversight of HMOs and ensuring there is compliance with the appeal and grievance regulations. To assist plans in these processes, OMC has created the appeal and grievance sections in the HMO/CMP Manual.

METHODOLOGY

We identified our universe of currently enrolled and recently disenrolled beneficiaries from the July 1995 update of the Group Health Plan master file maintained by HCFA. This universe consisted of 2,171,946 beneficiaries who were enrolled on January 1, 1995 and had not disenrolled, and 381,871 beneficiaries who had disenrolled between June 1, 1994 and June 30, 1995. From this universe, we selected a stratified random sample of 410 enrollees and 500 disenrollees. Three beneficiaries were dropped from the enrollment sample file as one had died and two had disenrolled since the update. We also dropped 113 beneficiaries from the disenrollment sample due to death. The final sample contained 794 beneficiaries (407 enrollees and 387 disenrollees). We received 426 questionnaires from respondents (222 enrollees and 204 disenrollees), representing a response rate of 54 percent. We analyzed the two groups (enrollees and disenrollees) separately. We also conducted an analysis, as explained in Appendix A, of respondents versus non-respondents to test for any bias of the survey results.

We supplemented the mail survey with more in-depth telephone interviews with those individuals indicating complaint experience. Of the 426 beneficiaries who responded, only 26 (6 percent) said they had filed a complaint. We were able to recontact 17 of these beneficiaries and 10 of them indicated they filed formal complaints.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

EIGHTY-SIX PERCENT OF RESPONDENTS WERE KNOWLEDGEABLE ABOUT THEIR GENERAL RIGHT TO MAKE A FORMAL COMPLAINT ABOUT THEIR HMO'S MEDICAL CARE OR SERVICES.

- In comparison, an earlier Office of Inspector General study² found that 75 percent of beneficiaries were aware of the ability to file appeals and grievances.
- Sixty-six percent of respondents indicated they were informed of their appeal and grievance rights when they first joined the HMO. In the telephone follow up survey, six respondents who indicated they were not informed when they first joined were asked when they learned. Three of the six learned of their right to appeal when the payment/services were denied (two learned when their referral was refused and one called the HMO when an out-of-plan hospital bill was received). Of the remaining beneficiaries, two responded that they just knew of their rights and one was still unaware.

HOWEVER, BENEFICIARIES WERE LESS AWARE OF SPECIFIC INSTANCES ON WHICH THEY MIGHT EXERCISE THEIR APPEAL AND GRIEVANCE RIGHTS.

- More than one third of beneficiaries did not know or were not sure of their right to complain about specific problems for which appeals and grievances are possible. Only 45 percent of respondents knew they could appeal when the plan decided to discharge them from the hospital when they believed they should stay. Also, 47 percent of beneficiaries were aware they could complain about non-admission to the hospital. (See Appendix B for the weighted analysis for those answering either no or not sure to these questions.)
- A majority of enrollees were aware of their right to complain about specific problems, but the level of understanding of the specific cases was lower than their general knowledge. (See Table 1 for these unweighted percentages.) For example, 66 percent of enrollees knew they could complain about not being provided Medicare covered services. However, only 49 percent of enrollees knew they could appeal when the plan decided to discharge them from the hospital when they believed they should stay.
- Among disenrollees the understanding was lower, as demonstrated by Table 1. Enrollees were twice as likely as disenrollees to be knowledgeable of their right to appeal a non-hospital admission or early hospital discharge. Additionally,

²Office of Inspector General, Department of Health and Human Services, 1994, *Beneficiary Perspectives of Medicare Risk HMOs*. (OEI-06-91-00730).

enrollees were three times as knowledgeable of their ability to contest the plan's refusal to pay a doctor or hospital for emergency care for which they were billed. Enrollees were also more aware of their ability to grieve about an HMO physician's behavior or their HMO facilities.

Table 1*

Beneficiary Awareness of Appeal/Grievance Issues*

Appeal Issues	Not Sure		No, Cannot File Appeal/Grievance		Yes	
	Disenrollees	Enrollees	Disenrollees	Enrollees	Disenrollees	Enrollees
your primary HMO doctor not providing Medicare covered services that you believe you need?	12% (17)	9% (18)	48% (70)	25% (50)	40% (58)	66% (129)
your HMO refusing to pay a doctor or hospital for your emergency care that you were billed for?	12% (17)	10% (20)	68% (95)	31% (59)	20% (27)	59% (112)
your primary HMO doctor not admitting you to the hospital when you believe you need to be admitted?	8% (11)	16% (30)	71% (96)	32% (61)	21% (29)	52% (98)
your HMO deciding to discharge you from the hospital when you believe you should stay?	10% (13)	19% (35)	71% (92)	32% (60)	19% (24)	49% (92)
your primary HMO doctor not referring you to a specialist?	7% (10)	9% (17)	56% (80)	31% (60)	37% (52)	60% (115)

Grievance Issues	Not Sure		No Cannot File Appeal/Grievance		Yes	
	Disenrollees	Enrollees	Disenrollees	Enrollees	Disenrollees	Enrollees
delays in getting to see your primary HMO doctor?	12% (18)	11% (21)	52% (79)	32% (63)	36% (54)	57% (112)
delays in getting to see a specialist?	6% (8)	10% (20)	54% (74)	30% (57)	40% (56)	60% (114)
your primary HMO doctor's behavior towards you?	11% (15)	8% (16)	58% (81)	30% (57)	31% (43)	62% (119)
your primary HMO doctor not taking your health complaints seriously?	8% (13)	9% (17)	55% (82)	27% (52)	37% (55)	64% (125)
your HMO facilities (such as cleanliness or safety)?	7% (9)	9% (17)	65% (85)	31% (58)	28% (36)	60% (114)

*Multiple responses were permitted in the survey document and not all beneficiaries responded to every question. See Appendix B for the weighted analysis and confidence intervals for those who answered either no or not sure to these questions.

Appendix B furnishes the weighted analysis and confidence intervals for those who answered no and not sure to these questions (see Table 1 for the unweighted percentages). When weighted, the sample approximates the disproportionate distribution of enrollees and disenrollees in the universe. A Chi-square test was performed to test for independence between being informed and enrollees versus disenrollees (see Appendix A). This test showed that these two factors are dependent with significant chi-square test statistics. However, the response rates to these questions were much less than the overall response rate to the survey. The disenrollees' responses ranged from 129-151 while the enrollees' responses ranged from 187-197. Therefore, the response rate for disenrollees for these questions was as low as 33 percent and the response rate for enrollees was as low as 46 percent.

- Forty-five percent of the respondents did not know, or were not sure that certain complaints are classified as appeals while others are classified as grievances. The protection afforded by external, impartial review in the appeals process is not afforded to grievance disputes. Beneficiaries who are unaware that their complaint is an appeal could potentially be denied the right to due process, or an independent Federal medical review for appropriateness of the HMO decision. The effect of this lack of knowledge could cause beneficiaries out-of-pocket liability and health risks from denial of needed services.

The distinction between appeals and grievances can be complicated. Even the HMOs who administer this program do not completely understand it. Additional support for this finding is found in the OIG companion reports³ which show that 50 percent of the HMOs are incorrectly identifying appeals as grievances. Likewise, review of actual appeal and grievance case files revealed that all of the plans visited incorrectly processed appeals as grievances in 26 percent of complaints reviewed.

MOST OF THE BENEFICIARIES WHO CONSIDERED THEY WERE DENIED SERVICES OR PAYMENT WERE NOT GIVEN INITIAL DETERMINATION NOTICES.

Inherent in the concept of managing care is the plan's ability to choose among acceptable alternative approaches to care. This means that beneficiary access to some services may be restricted, even if the beneficiary wants or thinks the services are necessary.

³Office of Inspector General, Department of Health and Human Services, 1996, *Medicare HMO Appeal and Grievance Processes: Survey of HMOs*. (OEI-07-94-00282).

Office of Inspector General, Department of Health and Human Services, 1996, *Medicare HMO Appeal and Grievance Processes: Review of Cases*. (OEI-07-94-00283).

The issues involving these decisions not to provide or pay for particular services and how they are resolved differ between fee-for-service and managed care. In the fee-for-service environment, beneficiaries are free to seek treatment from another provider if their physician does not believe a particular service should be provided. By contrast, managed care beneficiaries' recourses may be limited to disenrollment or being held financially liable for obtaining services outside the plan.

Because of these lock-in provisions of risk HMOs, the appeals and grievance regulations were established to provide a recourse for Medicare beneficiaries when they disagree with an HMO's denial of a service or payment for a service. This indication of disagreement by the patient can be verbal or in writing, directly with the HMO physician when receiving health services or later with designated HMO offices, such as customer services. When a beneficiary disagrees, the HMO is required to issue a written determination notice to the beneficiary reflecting the reasons for the denial and the beneficiary's right to seek a reconsideration. The HMO/CMP Manual instructs HMOs to "Educate plan physicians and representatives on beneficiary appeal rights, including how and when a member may file an appeal. If a physician denies an enrollee's request for a service, he/she should ask the enrollee if he/she would like to appeal. The plan must issue a written determination to the member whenever the member disagrees with the physician's decision or wants to appeal a service denial."

It was our design in the survey to find out if beneficiaries who believed that they had been denied a referral to a specialist, or had been denied payment for a medical service, had received proper written notification. Although we did not validate their responses with their respective HMOs, our survey does indicate that some beneficiaries who considered that they were denied services or payment were not given initial determination notices. We found that:

- Forty-one respondents believed that they had been refused referral to a specialist. Only three of these 41 stated they received a letter explaining why they could not get this care. Thirty-four of the 41 indicated they did not receive a notice that the referral was denied. Three others were not sure if they got a letter and one did not respond to this question.
- Thirty-nine respondents stated their plan refused to pay a claim for services. Of these 39, 21 indicated receiving a letter furnishing their appeal rights. Nine respondents did not receive a notice, six were not sure, and three did not answer.

We understand that the subject of written initial determinations is quite complex. Patients do not always clearly express a request for referral to a specialist or clearly indicate to their primary care physician that they believe such a referral has been denied them. Likewise, this ambiguity can lead patients to believe that services have been denied while the primary care physician believes that additional diagnostic or alternative treatment protocols are being pursued prior to making a final decision on referral to a specialist. However, the explanation may simply be that the HMO has

not adequately educated both the physician and the beneficiary about how and when a member can appeal denials of services. Furthermore, the procedures for providing these notifications may simply be inadequate.

This is consistent with a companion report⁴ on case file reviews which found 27 percent of appeal files lacked documentation that an initial determination was issued. In that inspection, we also found that five HMOs sent initial determinations in six cases without including the required appeal rights.

VERY FEW RESPONDENTS REPORTED FILING A FORMAL COMPLAINT. ALL OF THESE COMPLAINTS WERE RESOLVED AT THE INITIAL DISPUTE LEVEL.

Twenty-six respondents reported filing complaints. We telephoned those who authorized contact, to obtain greater insight into beneficiary knowledge. We were able to reach 17 beneficiaries, 10 of which indicated they actually filed a formal complaint. Three of the remaining seven acknowledged they did not file complaints; two characterized their complaints as informal; one complained to the nursing home; and one attempted telephoning the HMO but was unsuccessful. This follow-up data suggests that only a small number of beneficiaries may be attempting to resolve access and payment for service problems through the appeal and grievance processes.

- Thirteen of the 26 mail respondents who filed complaints reported they received a favorable resolution, however 5 were not sure (see Table 2). Seven received unfavorable decisions and one beneficiary did not respond. This is supported in the telephone survey we conducted, where only 5 of the 10 who formally complained indicated receiving a favorable resolution (See Table 3). Despite this favorable decision, two of the five beneficiaries switched to a different plan and one returned to fee-for-service.
- Of the seven beneficiaries reporting an unsatisfactory outcome in the mail survey, six were disenrolles (See Table 2). We did not determine if the disenrollees returned to fee-for-service or whether these beneficiaries switched to another plan. A slightly lower percentage of disenrollment was experienced by those who appealed based upon our follow-up telephone survey; 4 out of 10 received an unfavorable decision and, when asked, 3 of these 4 switched to another plan (See Table 3). The fourth beneficiary stayed with the HMO but switched their primary care physician.

⁴Office of Inspector General, Department of Health and Human Services, 1996, *Medicare HMO Appeal and Grievance Processes: Review of Cases*. (OEI-07-94-00283).

**Table 2
Mail Survey**

Decision	Enrollees	Disenrollees	Total
Favorable	3	10	13
Unfavorable	1	6	7
Not Sure	3	2	5
Blank	1	0	1
Total	8	18	26

**Table 3
Telephone Survey**

Filed Complaint = 10	Yes	No	Not Sure
Favorable Decision	5	4	1
Switched HMOs	2	3	1
Returned to FFS	1	0	0
Switched PCP	0	1	0

- One of the three respondents notified of a refusal to refer filed a complaint. Only 6 of the 34 beneficiaries not notified filed a complaint.
- Eight of the 21 respondents notified of a claim denial filed a complaint. Only one of the nine who were not notified complained.
- All complaints were resolved at the initial dispute level, or simply dropped by the beneficiary. No one in either of our surveys requested further review of their denied complaints. This supports a study conducted by NDG⁵ in which they found that the majority of enrollees who "jump" out of plan (usually out of dissatisfaction), do not first attempt to resolve differences with plan providers or through plan grievance systems.

The low number of beneficiaries who did not file a formal complaint, out of those who considered they were denied, could be due to many reasons. Possible reasons include: the beneficiaries did not want to contest the HMO decision; they agreed with the physician; or the beneficiaries did not know they could file an appeal.

⁵Richardson, David A., James Phillips, Dean Conley, Jr., "A Study of Coverage Denial Disputes Between Medicare Beneficiaries and HMOs," Network Design Group, Inc., under HCFA Cooperative Agreement No. 17-C-90070/2-01, September 1993.

RECOMMENDATIONS

Health Care Financing Administration's (HCFA) Office of Managed Care is making substantial efforts to improve the HMO appeal and grievance processes. It has recently created a work group - Managed Care Appeals and Grievance Initiative - organized to make program improvements in these functions. Appeals language has been standardized in "lock in" and Evidence of Coverage notices, which are sent to all beneficiaries when they enroll in an HMO. In addition, appeal and grievance information was included in the 1996 Medicare Handbook, and expanded information on appeals was incorporated into HCFA's Managed Care Directory. Currently HCFA is working with HMOs to develop national guidelines for marketing materials.

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To receive full benefits of the appeal and grievance protections, beneficiaries need to be aware of the processes, understand how the processes work, and when to use them. In that vein, HCFA should

- ***actively monitor HMOs to ensure beneficiaries are issued written determinations, including appeal rights, and emphasize the need for beneficiaries to communicate clearly any disagreement they have with HMO decisions to deny services or payment for services.*** This can be accomplished by:

- continuing HCFA's extensive efforts to make beneficiaries aware of appeal and grievance provisions and of the need to communicate clearly any disagreement they may have with a physician's decision to deny a requested service and
- emphasizing to HMOs the requirements to make beneficiaries aware of appeal and grievance rights and to provide written initial determination notices when the patient communicates disagreement with a decision to deny a requested service or payment.

Federal regulations are intended to protect the rights of beneficiaries to appeal the denial of services by HMOs, while maintaining the ability of the physician to treat the patient in line with his or her medical judgment. It is not always possible at the time of service for the physician to know whether a beneficiary believes that a service has been denied unless the beneficiary specifically communicates this to the physician. Therefore, future HMO marketing,

enrollment, and awareness sessions with Medicare beneficiaries and physicians should emphasize the importance of clear and open communication.

● ***work with HMOs to establish standardized appeal and grievance language requirements in marketing/enrollment materials and operating procedures.***

- In marketing materials, provide up front information to beneficiaries on their rights under the appeal and grievance processes and
- In enrollment materials, more thoroughly educate beneficiaries about their specific rights under the appeal and grievance processes, including
 - a detailed overview of the types of services, lack of services, or situations which may be appealed or grieved.
 - when and under what circumstances further levels of appeal are permitted.
 - clarification that only appeals and not grievances, are subject to independent Federal review.
 - the difference between the definitions of emergency and urgent care at the time medical services are being sought.

AGENCY COMMENTS

We solicited and received comments on our draft report from HCFA. The complete text of their response is included as an appendix to this report. A summary of their comments and our response follows.

The HCFA agreed with the conclusion of our reports that improvements are needed and indicated that they are working to implement a number of our recommendations. We are pleased that HCFA agrees that improvements are needed in the appeal and grievance processes, and we recognize that changes are in the process of being made through the Medicare Appeals and Grievance Initiative (MAGI). However, because HCFA's response does not specifically address the recommendations contained in our reports, we are unsure whether the problems identified in our report will be fully addressed through this initiative. As a result, it will be important for HCFA to include in their response to the final report an action plan that specifically addresses each recommendation.

Although HCFA acknowledges the case review report identifies mistakes made by health plans, they expressed concerns about the sample sizes and number of cases reviewed. We agree that this sample could not be used to make national projections of the incidence of mistakes. However, the number of cases reviewed and outcomes of the reviews are more than adequate to indicate the existence of significant problems in HMO processing of appeals and grievances.

Finally, HCFA raised questions about the knowledge and expertise of the individuals who prepared the HMOs' responses to our survey documents. We requested and must assume that knowledgeable HMO staff completed our survey. We also note that beneficiaries making inquiries regarding appeals and grievances are likely to be interacting with these same individuals or their staff.

APPENDIX A

ANALYSIS OF RESPONDENTS VS. NON-RESPONDENTS

An important consideration in surveys of this type is the bias that may be introduced into the results if the non-respondents are different than those who responded to the survey. As a test for the presence of any bias, we obtained information from the Enrollment Database on all of the individuals whom questionnaires were sent. The variables we analyzed were selected because they might determine whether an individual would respond to the survey, as well as affect the individuals' actual response. For all 794 individuals selected for the sample, we analyzed age, race and sex. Race and sex are categorical variables which were tested using a chi-square with the appropriate degrees of freedom. Age is a continuous variable which was tested using the t-statistic. for a difference between means.

The results are presented in the attached table. The Chi-square values given in the table provide a test of the difference in the distribution of the respondents versus the non-respondents for the variable of interest. Also provided in the tables are the response rates by the difference values of the variables.

The Chi-square test statistic was not significant when the variable sex was analyzed. Therefore, we conclude that whether or not an individual responded was not related to their sex.

When the respondents vs. non-respondents were analyzed by race, the response rate was dependent on race. Race was categorized by white vs. non-white since the numbers would have been too small to analyze if all five race categories were kept separate. To determine the effect of the relationship between response rate and race, we undertook an analysis of the non-respondents. Assuming that the non-responders would have responded the same as the responders by enrollee and disenrollee, we calculated a hypothetical global response to the question of being informed of grievance and appeal rights when first joining the HMO. This calculation gave an estimate of those claiming they were informed of their appeal and grievance rights when they first joined of 64.5 percent which differs by 2.1 percentage points from the 66.4 percent overall rate found among responders.

Age was analyzed using a comparison of means with the t-test. Although the t-statistic was significant, the difference in the mean ages for responders vs. non-responders was only 1.26 years. Since the sample size was 794, this small difference was significant. Had a smaller sample been selected this difference would not have been significant. Therefore, no adjustments were made based on a bias of age.

The tables below show the results of the chi-square for the sex and race variables and t-test for the age variable.

RESPONDERS VS. NON-RESPONDERS

SEX

Sex	Responders		Non-Responders		Total	% Responding
Male	185	43%	143	39%	328	56%
Female	241	57%	225	61%	466	52%
Overall	426	100%	368	100%	794	54%

CHI-SQ=1.70

DF=1

RACE

Race	Responders		Non-Responders		Total	% Responding
White	391	92%	296	81%	687	57%
Non-White	32	8%	69	19%	101	32%
Overall	423	100%	365	100%	788	54%

CHI-SQ=22.54*

DF=1

T-TEST FOR AGE

Beneficiaries	Sample Size	Mean
Respondents	368	73.67
Non-Respondents	426	72.41

t=2.09*

df=792

*Statistically significant at the 95 percent confidence level

APPENDIX B

ESTIMATES AND CONFIDENCE INTERVALS

The chart below summarizes the estimated proportions and the 95 percent confidence intervals for key statistics presented in this report. The estimates refer to the beneficiaries' understanding of their appeal and grievance rights as well as their knowledge of various situations for which they may file complaints.

Survey Question	Weighted Percent	95% Confidence Interval
Finding #1, Most Respondents Are Knowledgeable About The General Right To File Appeals And Grievances		
Proportion of beneficiaries who knew they have the right to complain	86.2%	82.2% - 90.2%
Proportion of beneficiaries who knew they could complain when they first joined	66.4%	60.8% - 72.1%
Finding #2, However, Beneficiaries Are Less Aware Of Specific Grounds On Which They Might Exercise Their Appeal And Grievance Rights. Proportion of beneficiaries who did not know or were not sure they could complain about:		
not being provided Medicare covered services	38.3%	32.5% - 44.1%
delays in seeing primary physician	46.0%	40.0% - 52.1%
their HMO refusing to pay for emergency care	47.2%	41.1% - 53.2%
their primary physician's behavior	42.7%	36.7% - 48.6%
their primary physician not taking health complaints seriously	39.7%	33.9% - 45.6%
non-admission to the hospital	52.7%	46.6% - 58.9%
early discharge from the hospital	55.4%	49.2% - 61.6%
non-referral to a specialist	43.6%	37.6% - 49.6%
delays in seeing a specialist	43.2%	37.1% - 49.2%
the HMO facilities (such as cleanliness or safety)	44.3%	38.2% - 50.4%
Finding #4, Almost Half Of The Respondents Did Not Understand The Difference Between Appeals and Grievances		
Proportion of beneficiaries who did not know or were not sure their complaints could be either appeals or grievances	45.0%	39.2% - 50.8%

APPENDIX C

Health Care Financing Administration Response to Report



DEC 12 1996

DATE:

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Medicare HMO Appeal and Grievance Processes--Overview," (OEI-07-94-00280); "Medicare HMO Appeal and Grievance Processes--Beneficiaries' Understanding," (OEI-07-94-00281); "Medicare HMO Appeal and Grievance Processes--Survey of HMOs," (OEI-07-94-00282); "Medicare HMO Appeal and Grievance Processes--Review of Cases," (OEI-07-94-00283)

We reviewed the above-referenced reports that examine the operations of the Medicare risk-based HMOs appeal and grievance processes. We agree with the conclusion of your report that improvements are needed and are working to implement a number of your recommendations. Our detailed comments are attached.

Thank you for the opportunity to review and comment on this report.

Attachment

**Health Care Financing Administration (HCFA) Comments
on Office of Inspector General (OIG)**

Draft Reports: "Medicare Health Maintenance Organizations' (HMO) Appeal and Grievance Processes: "Overview," (OEI-07-94-00280); Medicare HMO Appeal and Grievance Processes: "Beneficiaries' Understanding," (OEI-07-94-00281); "Medicare HMO Appeal and Grievance Processes: "Survey of HMOs," (OEI-07-94-00282); "Medicare HMO Appeal and Grievance Processes: "Review of Cases," (OEI-07-94-00283)

OIG Recommendations

OIG recommends that HCFA take the following actions to address problems highlighted in the above studies:

- o Actively monitor HMOs to ensure beneficiaries are issued written determinations.
- o Work with HMOs to establish standardized appeal and grievance language requirements in marketing/enrollment materials and operating procedures.
- o Ensure that HMOs correctly distinguish and process appeals and grievances.
- o Require HMOs to report Medicare contract-specific data on appeal and grievance cases.
- o Modify the HMO/CMP Manual to clarify and specify key requirements.
- o Broaden efforts to formally train HMOs on the appeal and grievance processes.

HCFA Response

We agree that improvements are needed. We have a comprehensive effort underway called the Medicare Appeals and Grievance Initiative (MAGI) which includes a number of objectives that are directly related to the recommendations in your reports. Our objectives include identifying and meeting the information needs of beneficiaries regarding their appeal rights; promoting health plan accountability by developing and improving information on appeals and making meaningful information more available; and refining mechanisms for monitoring and assisting in the continuous improvement of health plan performance.

OIG and HCFA jointly issued a Medicare beneficiary advisory bulletin entitled, "What Medicare Beneficiaries Need to Know About HMO Arrangements: Know Your Rights." This easy-to-read document contains information on appeal rights, filing complaints, and rights to emergency and urgently needed services. Copies of this bulletin are being distributed nationally. Additionally, significant changes were made to improve the managed care portions of the Medicare Handbook, which was sent to all beneficiaries this year. New data reporting requirements on plan-level reconsiderations are under development and may be instituted as early as mid-1997. We also plan to restructure and shorten the time lines for handling health care decisions and reconsiderations by health plans.

Beneficiaries' Understanding

We are pleased to see the high level of knowledge among Medicare enrollees regarding their right to appeal and file complaints. This is an improvement over an earlier finding, and one we believe results from both Federal program and plan efforts at educating beneficiaries and providing notices. With regard to the finding that beneficiaries had a lesser level of awareness as to when to exercise their appeal rights, forthcoming regulations clarifying the right to appeal when services are reduced or terminated, and when to provide notices of noncoverage at these points in care management, should significantly help address this problem. We will consider the recommendations in this area.

Survey HMOs

Incorrect categorization of appeals as grievances is an area for improvement identified in our MAGI initiative. However, we question the percentage and methodology set forth in this report. Because certain staff within the organizational structure of an HMO, or staff at delegated medical groups within the HMO's network, are generally responsible for assigning complaints to the appeals or grievance track, it would be important to know who responded to the two questions asked on this subject and what role they play in this particular process. We will be moving to identify the source problems, such as staff turnover and confusion over differences in Federal and state terminology.

The type of statistical information sought by OIG staff has not been a requirement for Medicare-contracting health plans. Therefore, it is not surprising that many plans aggregate the appeals information across commercial, Medicare, and Medicaid members. New plan-level appeals reporting requirements should resolve the need for Medicare-only information, and respond to your recommendation.

Review of Cases

We have concerns about the small sample sizes and number of cases used to present findings in this report. However, the report identifies the types of mistakes health plans make in operating an appeals system, and the needs that plans have for clear, distinct information and training about the Medicare managed care requirements (and how these differ from state requirements for their commercial and Medicaid enrollees). We will consider the recommendations presented.